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Improving the Application of Gynecological Operations in the Practice of Gynecologists and Surgeons

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Abstract The results of the analysis are presented in the article. The surgical approaches used are used to perform simultaneous operations, since, subject to the above conditions, they do not pose a great danger to patients who received treatment in the 3rd maternity hospital in the city of Samarkand from 2016 to 2020. It was found that laparoscopic gynecological simultaneous operations performed in a completely laparoscopic manner and when combined with traditional approaches reveals the advantages of this method, primarily due to low invasiveness and cosmetic effect. Indications and selection criteria for patients for this operation are presented, the effectiveness of the proposed method of surgical treatment based on the study of immediate and long-term results is determined. The article gives the dynamics of the state of the organs of the reproductive system and quality of life during the year after the operation.

Keywords Simultaneous operations, Women of reproductive age, Diagnosis, Surgical treatment

1. Introduction

The problem of surgical treatment of combined diseases of the abdominal organs has long attracted the attention of specialists in various fields. According to WHO, 20-30% of patients have comorbidities, 4-7% of them require simultaneous operations. This is not associated with an increase in the number of diseases, but is a consequence of an increase in the life expectancy of the population, an improvement in the level of diagnostics, achievements in surgery, anesthesiology and resuscitation. The introduction of new economic relations in our country requires the improvement of treatment methods for patients with simultaneous gynecological and surgical pathology, due to their prevalence among women of childbearing age, i.e. among the most able-bodied part of the population, since the amount of economic damage as a result of temporary and permanent disability is very significant. There is no single point of view on the indications and contraindications for simultaneous laparoscopic operations in women with combined surgical pathology of the abdominal organs and gynecological diseases, the choice of surgical access, the volume and sequence of certain stages. In operative gynecology, effective methods of simultaneous laparoscopic interventions have not been developed. There are no data on the comparative assessment of the course of the early and late postoperative periods. Many technical, tactical, moral and ethical issues related to the performance of simultaneous operations by surgeons and gynecologists still remain open.

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Improving diagnostics, improving operational techniques and the success of anesthesiology and resuscitation have significantly expanded the possibilities for performing simultaneous operations. The ubiquity of endoscopic surgery has provided a unique opportunity to redefine the boundaries of two specialties - surgery and gynecology, since operative laparoscopy is not only equivalent to, but also preferable to classical treatment. In the scientific literature, reports of this are rare, although in practice, many surgeons and gynecologists note the need to perform such operations.

In this regard, the purpose of our work was to improve the methods of combined surgical treatment of diseases of the pelvic organs and the abdominal cavity.

2. Purpose of the Study

To determine the effectiveness of the results of patients with combined gynecological and surgical pathology.

3. Materials and Methods of Research

The study included an analysis of the results of surgical treatment of 185 patients with various concomitant diseases of the abdominal organs, who underwent simultaneous surgical intervention.

The patients were divided into two main groups. The first group included 107 patients who underwent laparoscopic and traditional simultaneous operations (main group), the second group included 78 patients with traditional surgery (control group) who underwent one isolated operation.

A comparison was made of the surgical approaches used in performing simultaneous operations. In the main group of patients 20-30 years old, there were 11 (5.9%), 31-40 years old 49 (26.5%), 41 and over years - 47 (25.4%) and, respectively, 6 (3.2%), 20 (10.9%), 52 (28.1%) years in the control group. The average age in the main group was 38.6±6.6, and in the control group 41.3±5.9 years. It should be noted that all patients were at the most able-bodied age. In the main group of 107 patients who underwent simultaneous laparoscopic interventions, 47 (43.9%) had calculous cholecystitis. Of these, chronic calculous cholecystitis occurred in 40 (85.1%), acute calculous cholecystitis in 7 (14.9%). In chronic calculous cholecystitis, cholecystectomy was performed by minilaparotomic access in 40 (37.4%) patients, with complete and incomplete prolapse of the uterus, transvaginal extirpation of the uterus was performed in 20 (18.7%) patients. Laparoscopically simultaneous stage of the operation was uterine myoma in 47 patients. In addition, the main group is characterized by a combination of mini-laparotomy and traditional operations. So, the simultaneous traditional stage of the operation for calculous cholecystitis was uterine myoma of various localization in 40 women, also with transvaginal extirpation of the uterus, the simultaneous stage was hernia repair for umbilical hernia in 20 patients. All patients were examined and prepared for surgery on an outpatient basis. Clinical examination of patients included a general blood and urine test, a biochemical blood test, ECG, chest x-ray, ultrasound of the pelvic organs, liver and gallbladder. Particular attention was paid to the degree of purity of the vagina, which should correspond to I-II degrees.

4. Research Results and Discussion

5120 laparoscopic operations were performed, of which 107 (2.1%) were simultaneous. In the control group, all patients underwent only isolated operations: hysterectomy in 33 (42.3%) patients, transvaginal hysterectomy in 21 (26.9%), cholecystectomy in 11 (14.1%) and ventroplasty in 13 (16.7%) patients. %), i.e. the same as those performed in the main group and also according to classical methods, but one operation for each patient. The decision on the conduct of simultaneous operations was made by a council with the participation of attending physicians, heads of departments, as well as with the participation of professors, associate professors and assistants of the Department of Surgery of the Faculty of Postgraduate Medical Education and the Department of Obstetrics and Gynecology of the Pediatric Faculty of SamMU. Laparoscopic cholecystectomy + laparoscopic hysterectomy was performed in 47 patients. Laparoscopic cholecystectomy was performed according to the standard technique: one 10 mm trocar was inserted through the navel, after which, under the control of a laparoscope, two 5 mm and one 10 mm trocars were inserted in the right hypochondrium along the anterior axillary, middle clavicular and midline. After the completion of the cholecystectomy operation, the laparoscope turned 1800°, the patient was transferred from the Fowler position to the Trendelenburg position, and a revision of the pelvic organs was performed. Laparoscopic extirpation of the uterus with appendages for fibroids in 47 cases was a simultaneous step to laparoscopic cholecystectomy. For such operations, the selection of patients was carried out carefully (the size of the uterus was not more than 12 weeks of gestation, the presence of a history of uncomplicated urgent delivery, the absence of laparotomies in the past and, as a result, the presence of a pronounced adhesive process, the absence of an inflammatory process in the gallbladder and genital organs). Fixation of the cervix and expansion of the cervical canal was carried out using the Claremont-Ferrand uterine manipulator in order to ensure the position of the uterus in anteversio and a certain position of the posterior vaginal fornix between the sacro-uterine ligaments. The ureters were isolated transparietally on both sides in the middle part of the posterior leaf of the broad uterine ligament. The uterine arteries were isolated transparietally and using a high-frequency coagulator AVTOKON 350, monocoagulation was performed in the "aerosol coagulation" mode with the effect of coagulation t3 (stage 3) and its coagulation was performed. The intersection of the round ligaments of the uterus, infundibulopelvic and sacro-uterine ligaments was also performed using monocoagulation. Dissection and bringing down the plica vesico-uterina was carried out with sharp and blunt scissors until the vagina was identified. Cutting off the cervix from the vaginal vaults was performed on the “anatomical zone” of the Claremont-Ferrand uterine manipulator. After that, the uterus with appendages was removed through the vagina and sutured from the outside with interrupted catgut sutures. Peritonization was not performed. At the end of the operation, the abdominal cavity was sanitized, a thorough examination and hemostasis of the surgical field and its drainage were performed. The postoperative period in 1 (0.5%) patient was complicated by the outflow of bile from the stump of the cystic duct. Produced relaparoscopy and the imposition of an additional titanium clip. There was no lethal outcome. Minilaparotomic cholecystectomy was performed with access through a pararectal incision, while the length of the incision did not exceed 6 cm, which was sufficient for safe manipulations in the area of the hepatoduodenal ligament. Laparotomic extirpation of the uterus was carried out according to the usual technique with a Pfannenstiel incision. The duration of the operation increased by 20 ± 1.2 minutes compared to laparoscopic surgery. Blood loss was in the range of 120-150 ml. In the postoperative period, 1 (0.5%) patient had parenchymal bleeding from the vaginal stump in the early postoperative period. A relaparotomy was performed - ligation of the internal iliac arteries. The postoperative period proceeded smoothly. There was no lethal outcome. Of greatest interest is the combination of transvaginal extirpation of the uterus and umbilical hernia. This pathology was in 20 patients. The indications for these operations were complete uterine prolapse, as well as stress

incontinence, vaginal prolapse and the presence of an umbilical hernia. The operation was started with hernia repair, since the presence of infection in the postoperative period in the umbilical wound can lead to recurrence of the hernia. The skin above the navel was dissected in a semicircle above or below the umbilicus. Then, the skin of the navel was separated from the surrounding tissues with a scalpel and the hernial orifice was isolated. The contents of the hernia were resected (most often it was the tissue of the greater omentum) and the hernial orifice was closed with interrupted sutures. Then proceeded to perform a hysterectomy through the vagina. The operation was started with the introduction of a vasoconstrictor solution to reduce bleeding of the vaginal tissues. After that, the anterior lip of the cervix was grasped with bullet forceps, the uterus was pulled back. A circular incision was made through all layers of the vagina, at a distance of approximately 3 cm from the external os of the uterus with a scalpel. Pulling the uterus to the symphysis, the recto-uterine space was exposed with a tupfer and opened with scissors, and the left and right sacro-uterine ligaments were alternately ligated. After these manipulations, the uterus became more mobile, and with the help of scissors, the plica vesico-uterina was opened. At the same time, in order to prevent injury to the bladder, the scissors were held perpendicular to the uterus. Then the uterine arteries, round ligament and infundibulopelvic ligaments were sequentially ligated. After checking hemostasis, the infundibulopelvic ligaments, round ligaments of the uterus were sutured together in order to form a strong, supporting suture under the peritoneum. The vagina was sutured with a continuous Vicryl suture.

A comparative study of two statistically comparable groups of patients who underwent simultaneous and single operations, according to clinical and laboratory studies, showed that there are no significant changes in the patient's body associated, specifically, with simultaneous interventions. Our experience in laparoscopic gynecological concurrent operations performed entirely laparoscopically and in combination with traditional approaches, reveals the advantages of this method, primarily due to low trauma and cosmetic effect. Therefore, when choosing access, we recently proceed from the possibility of performing any operation or stage in any low-traumatic way, whether it be laparoscopic or mini access. When using combined access, i.e. laparoscopic for one of the stages and classical for another, we also noted a milder course of the postoperative period in patients, but they had longer postoperative pain at the site of the classic incision, so they recovered more slowly in the immediate postoperative period. The level of complications approached the group of patients in whom all operations were performed through classical approaches. According to our data, the total duration of the operation in the main group was 87.13±13.2 minutes, and in the control group 77.13±11.1 minutes. When performing laparoscopic simultaneous operations, the total duration of the operation decreased by an average of 21 minutes.

Thus, with high professionalism and accumulated experience of operators, as well as highly qualified anesthesiology and resuscitation support, simultaneous operations in surgery and gynecology through classical and combined accesses can take their rightful place in the practice of departments, since, subject to the above conditions, they do not pose a great danger. for patients, and positively perceived by them.

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